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| **Agency:** | **107 Health Care Authority** |
| **Decision Package Code/Title:** | **ML2-FB Support HBE Shared Costs** |
| **Budget Period:** | **2015-17 Biennial Submittal** |
| **Budget Level:** | **ML2 – Maintenance Level 2** |

## Recommendation Summary Text

The Health Care Authority (HCA) requests $57,920,000 and 5.0 imaging FTEs in the 2015-17 biennium for Medicaid and Children's Health Insurance Program (CHIP) allocated operational costs from the Washington Health Benefits Exchange (HBE). The HBE operates and maintains the HealthPlanFinder (HPF) website and supporting systems which determines eligibility and enrollment for applicants of subsidized health care coverage. The HPF operations costs generally qualify for 75 percent Federal Financial Participation (FFP), and 50 percent FFP for certain customer support services and general administrative activities.

## Package Description

This request provides the funding needed to meet anticipated costs from the HBE for operating and maintaining systems and services that benefit the HCA's clients. With the implementation of the Modified Adjusted Gross Income (MAGI)-based rules for Medicaid eligibility determinations, over 1.4 million Medicaid and CHIP clients now have their eligibility records maintained through the HPF website and other related systems. In addition, new Medicaid and CHIP applicants will continue to use the HPF website to apply for subsidized health care benefits provided under the Affordable Care Act (ACA). On an ongoing basis, the existing clients will access the HPF to update their client records when needed, receive correspondence generated by that system, and utilize the HBE operated customer support services Call Center.

Generally, HBE-administered activities that are cost allocated to Medicaid and CHIP provide the HPF website functionality, client communications, customer support, and eligibility determination support services. The Authority's share of these costs is based on a methodology that reflects the proportion of Medicaid and CHIP clients using the HPF system. Costs allocated to the HCA include: 1) the HPF-related Operations and Maintenance (O&M) costs (contractor based activities, the HBE staff, and software licensing fees); 2) Operating costs for the HBE Call Center; 3) Print Services (contractor managed correspondence services shared between the HBE and the HCA); 4) Imaging Services; and 5) certain In-Person Assistor/Navigator costs provided to the HPF applicants.

**Status of Health Benefit Exchange Grant Funded Activities**

Since the HPF system was designed, in part, to operationalize the MAGI Medicaid eligibility rules, a portion of the HBE design, development, and implementation (DDI) costs were cost allocated to the Medicaid and CHIP programs administered by the HCA. The DDI work by the Exchange was funded through grants awarded by the Centers for Medicare and Medicaid Services (CMS), the Centers for Consumer Information and Insurance Oversight (CCIIO). Washington received four grant awards including a Planning Grant, two Level One Establishment Grants and a Level Two Establishment Grant for a total of $266 million. This funding is scheduled to end December 31, 2014 at which time the HBE is required to be "self-sustaining". Most of the Level One and Two grant funding included cost allocation to Medicaid for a portion of DDI-related costs. As the HBE winds up the DDI phase of its operations, Medicaid cost allocation for these activities will end. Since it is anticipated this will occur prior to the beginning of state fiscal year 2015, this request includes no DDI-related cost allocation amounts.

**HealthPlanFinder Operations and Maintenance Costs $25,372,000**

The HPF is a web-based portal used by persons applying for subsidized health coverage in the State of Washington. The HPF uses the MAGI Medicaid eligibility rules to adjudicate new applications for health coverage and the majority of Medicaid coverage groups are now subject to these new rules, including adult members of the Family, Children, and Pregnancy programs, and other adults with incomes up to 138 percent of the federal poverty level (FPL). These rules also form the basis for determining eligibility for subsidized health coverage through the Qualified Health Plans (QHP) administered by the HBE. As of July, 2014, over 1.2 million Washington residents have completed their renewal or enrolled in Medicaid and CHIP through the HPF under the new MAGI-based rules.

The portion of the HPF's operating expenses related to supporting Medicaid and CHIP eligibility and enrollment can be cost allocated for purposes of claiming enhanced FFP. These allocated costs include contracted HPF and supporting IT systems maintenance services, certain licensing fees for software, and the Exchange IT staff time spent in supporting the HPF operations.

The modular architecture of the HPF provides the basis for determining the share of O&M costs charged to the Medicaid and CHIP programs. The HPF design includes seven modules. Of these, three support Medicaid and CHIP eligibility and enrollment. The initial share, then, of allocated HPF O&M costs is determined by applying a factor of 42.8 percent (3 divided by 7) to total O&M costs. System usage is the basis for the second step in the allocation methodology and this measure relies on reported enrollment data for the Medicaid, CHIP and QHP programs. Based on July 2014 reported enrollment, 88 percent of shared costs described above would be attributed to the Medicaid/CHIP programs with the balance (12 percent) attributed to the HBE QHP enrollee activity.

**The HBE Customer Support Call Center Costs $24,225,000**

Under federal rules governing state operated health insurance exchanges, the exchange must provide call center services. The HPF system requires ongoing customer support for persons applying for subsidized health coverage and for those who need to renew eligibility or make changes to their eligibility record. The HBE provides these call center services through a contract with Faneuil, Inc. This contractor provides the Customer Service Representative (CSR) resources to field calls from consumers seeking health care coverage through the HPF and who need assistance with system navigation or data entry for applications, renewals or changes of circumstance.

The HCA, in cooperation with the HBE, has developed a cost allocation methodology to identify HCA's share of Medicaid-related Call Center costs based on resource usage. The HBE will document incoming calls through their Contact Management System (CMS) according to subject matter (Medicaid/CHIP-related, Qualified Health Plan-related, or general Inquiries regarding health coverage options) and tally the number and length of the calls by these categories. These results will be the basis of an initial allocation calculation which determines percentage shares attributed to each category. The monthly billed costs for call center operations will then be apportioned according to the calculated percentage. Calls categorized as "general" will be apportioned using the reported enrollment data for the Medicaid, CHIP and QHP programs. (88 percent to Medicaid and the CHIP , and 12 percent to the QHP enrollee activity and other HBE-exclusive support activities).

**Correspondences - Print and Postage Services $4,979,000**
The HBE system contains processes that generate automated notifications of required correspondences with applicants, enrollees, and other HBE business partners. Production and distribution of required correspondence is managed under a contract with KP Corp. Correspondences from the Exchange are generally one of three types: 1) Medicaid-only; 2) joint Medicaid/Exchange mailings; or 3) HBE-only letters. There are 15 separate letters pertaining to client eligibility and enrollment that are generated as needed by the correspondences module of the HPF, with some that are Medicaid and CHIP specific and others that go to households with mixed eligibility status (e.g., parents are QHP enrollees while their children are CHIP enrollees).

The Exchange incurs the total cost related to the print and mailing services contract. The HCA will reimburse the HBE for these costs, based on a periodic measure of actual usage (page counts).

**The HCA Managed Imaging Services $2,113,000**
The HCA provides document management and imaging services to the Exchange for paper applications and supporting documents received from applicants of subsidized health care coverage. These document services are provided by the Authority under the terms of the HCA/HBE Cooperative Agreement and related Service Level Agreement. The HBE is billed for the full cost of each month's services, determines the portion of imaged documents that are attributable to Medicaid applicants, and subsequently invoices the HCA for the resulting costs.

Since the implementation of the ACA in Washington, the volume of paper-based Medicaid applications has grown significantly. There are two reasons for this. First, ACA Medicaid expansion sparked actual caseload growth far exceeding the forecasted estimates by 177 percent. Second, the HBE system experienced issues during implementation that required the use of manual processes to assist those applying for health care coverage. The enormous volume of paper documents hinders the ability of the Authority's Office of Imaging Services (OISS) to image and accurately "digitize" all paper documents related to a consumer's application within 24 hours of receipt. To meet this requirement, the HCA is requesting an additional 5.0 FTEs and $698,000 total funds ($189,000 GF State).

**HBE Navigators $1,231,000**
Navigators (aka In Person Assistors or IPAs) provide Washington residents with impartial information to assist their search for health care coverage through the Exchange. Navigators use in-person meetings, online communications and phone-based interactions to connect with and assist applicants. Navigators are certified by the HBE and receive ongoing training to support their "front line" relations with the applicants. During the initial open enrollment period, navigators/IPAs were instrumental to the completed enrollment of over 175,000 newly eligible Apple Health clients, over 43 percent of the total population of newly eligible Apple Health enrollees.

A number of the HBE Navigators are affiliated with certain Community Based Organizations (CBOs) that participate in the Medicaid Administrative Claiming program administered by the HCA. In order to remove the possibility of duplicate federal claims for outreach, enrollment and other client

assistance, the HBE and the HCA have agreed to exclude these CBOs and their Navigator affiliates from the planned cost allocation related to the HPF enrollment assistance. In addition, under current federal guidance regarding claims for enhanced FFP for activities supporting enrollment of Medicaid applicants, states are required to account for those activities that directly contribute to a completed eligibility determination and other activities that are more general in nature.

With these constraints, the HCA assumes a limited ability to claim the biennial $1,231,000 (total funds) allocation of the HBE Navigator for the enhanced 75 percent FFP rate and assumes that qualifying costs will be limited to 50 percent or $615,500.

It has been noted by the HBE that costs related to Navigator contracts could change in the coming period should additional funding become available. The HCA will request supplemental funding to meet any additional costs that may result from this increase.

Questions related to this request should be directed to Steve Cole at (360) 725-1473 or at Steven.Cole@hca.wa.gov.

## Fiscal Detail/Objects of Expenditure

| | FY 2016 | FY 2017 | Total |
|---|---|---|---|
| **1. Operating Expenditures:** | | | |
| Fund 17T-1 Health Benefit Exchange | $ 8,257,000 | $ 9,225,000 | $ 17,482,000 |
| Fund 001-C GF-Federal Medicaid Title XIX | $ 19,085,000 | $ 21,353,000 | $ 40,438,000 |
| **Total** | **$ 27,342,000** | **$ 30,578,000** | **$ 57,920,000** |

| | FY 2016 | FY 2017 | Total |
|---|---|---|---|
| **2. Staffing:** | | | |
| Total FTEs | 5.0 | 5.0 | 5.0 |

| | FY 2016 | FY 2017 | Total |
|---|---|---|---|
| **3. Objects of Expenditure:** | | | |
| A - Salaries And Wages | $175,000 | $175,000 | $350,000 |
| B - Employee Benefits | $72,000 | $72,000 | $144,000 |
| C - Personal Service Contracts | | | |
| E - Goods And Services | $27,055,000 | $30,331,000 | $57,386,000 |
| G - Travel | | | |
| J - Capital Outlays | $40,000 | | $40,000 |
| N - Grants, Benefits & Client Services | | | |
| Other (specify) - | | | |

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| **Total** | **$27,342,000** | **$30,578,000** | **$57,920,000** |

| | FY 2016 | FY 2017 | Total |
|---|---|---|---|
| **4. Revenue:** | | | |
| Fund 17T-1 Health Benefit Exchange | $ 8,257,000 | $ 9,225,000 | $ 17,482,000 |
| Fund 001-C GF-Federal Medicaid Title XIX | $ 19,085,000 | $ 21,353,000 | $ 40,438,000 |
| **Total** | **$ 27,342,000** | **$ 30,578,000** | **$ 57,920,000** |

## Narrative Justification and Impact Statement

**What specific performance outcomes does the agency expect?**
Under the ACA, Washington State was required to implement the MAGI eligibility rules for individuals who are eligible for Family, Children and Pregnancy Medicaid. Maintenance and operations of the IT and other systems supporting MAGI implementation is therefore also required. Failure to comply with the related ACA regulations could lead to sanctions to Washington's Medicaid program.

Implementing the MAGI methodology and integrating Medicaid with the Exchange has allowed individuals and families to apply for the health insurance affordability programs by using one streamlined and seamless application process, removing barriers to Washington residents who seek health coverage.

**Performance Measure Detail**
**Activity Inventory**
H005 HCA National Health Reform

**Is this decision package essential to implement a strategy identified in the agency's strategic plan?**
The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. This request supports the HCA mission by sustaining access to affordable health care and better health care outcomes for uninsured and under-insured Washingtonians.

Funding for this request will support ongoing streamlined eligibility processing for nearly two-thirds of the existing Medicaid caseload through application of the MAGI rules as implemented in the Exchange.

**Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?**
This request continues to support the ongoing implementation of Health Care Reform, which has had a significant impact towards ensuring that all individuals in Washington have access to affordable health care.

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**What are the other important connections or impacts related to this proposal?**
The mandatory implementation of the MAGI rules for Family, Children and Pregnancy caseloads has continuing support from the numerous Medicaid and CHIP program stakeholders including the hospital association, legal service community, migrant and rural health organizations, and community based organizations.

Client advocacy groups, insurance carriers, the Department of Social and Health Services and the Office of Insurance Commissioner all are stakeholders with ongoing interest in successful operation of the HBE.

**What alternatives were explored by the agency, and why was this alternative chosen?**
Instead of choosing to use the Federally Facilitated Exchange as the system for operationalizing MAGI Medicaid eligibility in Washington, the State of Washington chose to develop its own exchange. This decision resulted in a functioning and effective state-operated HBE that currently serves over 1.4 million health coverage program enrollees and the successful culmination of years of policy implementation efforts supported by bipartisan legislation and funding.

This proposal is required to meet the requirements under federal cost allocation rules where benefiting programs (including Medicaid and CHIP) must participate in the expense of operating an exchange. Under the CMS rules implementing the ACA, benefiting programs qualify for 75 percent FFP for IT system operations and maintenance, and 50 percent FFP for other supporting services. This proposal requests state funding and federal authority for those HBE operational costs which are expected to qualify under these rules.

**What are the consequences of adopting this package?**
Funding of this request will ensure continued operation of the HBE systems that are now used by the majority of Medicaid and CHIP clients for maintenance of program eligibility and by new, uninsured applicants seeking subsidized health coverage.

**What is the relationship, if any, to the state capital budget?**
None

**What changes would be required to existing statutes, rules, or contracts, in to implement the change?**
None

## Expenditure and Revenue Calculations and Assumptions

*Revenue Calculations and Assumptions:*
The HCA assumes federal grant funding for DDI work will end January 1, 2015 and that all subsequent allocations for federal claims will be tied to operational activities of the HBE. The HCA assumes that the HBE will adhere to the agreement resulting from the interagency workgroup that jointly developed the methodologies to be applied in determining each organization's shares of the

HBE operational expenses. The HCA assumes the cost allocation methodology will be approved by the CMS and that federal funding will be available for operational activities beginning October 1, 2014.

*Expenditure Calculations and Assumptions:*
The HCA relied on the HBE budget estimates for the activities identified in this request for cost allocation during the 2015-17 Biennium. The HCA assumes that estimates provided by the HBE for the five functional areas described above are "the best available" values for purposes of this request. The HCA also assumes the final budget values from the HBE will not be available until early September and an updated fiscal estimate of the HBE costs will be required before the Governor's budget is finalized. The HCA relied on the June CFC Medical Assistance caseload draft forecast for determining proportional shares of the HBE versus the HCA allocated costs and assumes that projected expenditure changes based on the CFC Fall 2014 forecast numbers will also be needed.

Please refer to the attached Excel workbook for details regarding projection methodologies, source data and working assumptions used in developing the expenditure projections supporting this request.

**Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?**
*Distinction between one-time and ongoing costs:*
Operational costs for the Exchange's HPF and related systems and services should be considered ongoing. FTE costs for the OISS are assumed to continue through the 2015-17 biennium.

*Budget impacts in future biennia:*
Operational costs included in this request will impact future biennia. Some remaining enrollment growth and inflation will affect the total costs of operating the Exchange. The HBE board decisions regarding assessments charged to plans for defraying the HBE operations costs in future periods can affect the amount of total costs allocated to Medicaid.

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